U.S. Department of Labor

Office of Administrative Law Judges
2 Executive Campus, Suite 450
Cherry Hill, NJ 08002

(856) 486-3800
(856) 486-3806 (FAX)

Issue Date: 31 May 2007

CASE NO.: 2004-BLA-05178

In the Matter of

H.T.,
Claimant,

v.

MILLER MINING COMPANY, INC.,
Employer,

and

KENTUCKY EMPLOYERS' MUTUAL INS.,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-interest.

Appearances:

WILLIAM LAWRENCE ROBERTS, Esq.,
For Claimant

PAUL E. JONES, Esq.,
For Employer

Before:

JANICE K. BULLARD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a subsequent claim for benefits under the Black Lung Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title

20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.[1]

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

On October 29, 2003, this case was referred to the Office of Administrative Law Judges ("OALJ") for a formal hearing. The case was scheduled for hearing, which was continued. The matter was then reassigned to me. I held a formal hearing on August 9, 2006, in Pikeville, Kentucky, at which time the parties had full opportunity to present evidence and argument.[2] The following decision is based upon a thorough review of the evidentiary record, the arguments of the parties and an analysis of the applicable law.

I. ISSUES

(1) Whether the Miner has pneumoconiosis pursuant to 20 C.F.R. § 718.202;

(2) Whether the Miner's alleged pneumoconiosis arose out of coal mine employment pursuant to 20 C.F.R. § 718.203;

(3) Whether the Miner is totally disabled pursuant to 20 C.F.R. § 718.204(b); and

(4) Whether the Miner's alleged pneumoconiosis substantially contributed to his total disability pursuant to 20 C.F.R. § 718.204(c).

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural History

On October 18, 2001, Claimant filed the instant claim for black lung benefits with the United States Department of Labor, Director of Office of Workers' Compensation Programs ("OWCP" or "Director"). DX 2. In Proposed Decision and Order of July 10, 2003, OWCP awarded benefits to Claimant. DX 25. Employer appealed and requested a hearing before OALJ. I held the hearing as scheduled, denying a request for continuance by the Claimant, but agreeing to hold the record open for the submission of evidence. Claimant's evidence was

[1] The Department of Labor ("DOL") has amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at C.F.R. Parts 718, 722, 725, and 726 (2002). They are applicable to all claims pending, on, or filed after that date. See 20 C.F.R. § 718.101(b)(2001); 20 C.F.R. § 725.2(c)(2001). Since Claimant's current claim was filed on October 7, 2003, the revised regulations apply to his claim. The United States Court of Appeals for the District of Columbia has upheld the validity of the revised regulations. See National Mining Assoc. v. Department of Labor, 292 F.3d 849 (D.C. Cir. 2002).

[2] In this Decision and Order, "DX-#" refers to Director's Exhibits; "CX-#" refers to Claimant's Exhibits; "EX-#" refers to Employer's Exhibits and "Tr. at -" refers to the Hearing Transcript of August 9, 2006.

finally completely submitted on May 23, 2007.[3] The parties filed briefs, and Employer filed a supplemental brief to address evidence submitted after the filing of its initial brief on December 11, 2006.

At the hearing, I admitted the evidence developed in the claim and contained in Director's file, which was identified as DX 1 through DX 31. However, because the parties continued to develop the record, some of the evidence in the Director's file was inadmissible, as it represented evidence that exceeded the evidentiary limitations imposed by 20 C.F.R. § 725.414. Accordingly, Employer agreed to rely upon the medical opinions of Dr. Dahhan and Dr. Jarboe. Therefore, I have excluded medical opinions by Dr. Broudy, found at DX 12, 23, and 24, from my consideration in this adjudication. See, Tr. at 14-16. I also excluded from the record medical records from Dr. Fino (EX 2 and 3), that were proffered by Employer, because they exceeded the limitations on the admission of evidence. See, Tr. at 13-15.

B. Factual Background

1) Stipulations of the Parties

The parties entered into the following stipulations during the formal hearing held before me:

1. The Miner worked in coal mine employment for at least twenty (20) years. (Tr. at 32).

2. Employer is the properly named responsible operator. (Tr. at 32).

3. Claimant has two dependents for purposes of augmentation of any benefits that may be found due. (Tr. at 32).

2) Claimant's Testimony

Claimant is married, and has one dependent child, age 15. He worked in the coal mines for approximately 24 years as a cutter, miner and shuttle car operator. Tr. at 21. He did all of this work at the face of the mine, which he described as the place where all the dust is. Tr. at 21-22. Claimant stated that the work involved bending, stooping and lifting heavy objects. Claimant's family doctor, Lela Maynar, treats him for his breathing condition, and also consulted Dr. Forehand for his problem. Tr. at 22-23. Claimant takes Flovent, Combivent, Albuterol and several nasal sprays called Nasonex, Astelin and Atrovent. Tr. at 23. He said that he cannot play

[3] Claimant submitted a "Revised Index to Medical Evidence" that refers to evidence that is not of record. First, Claimant refers to a report of Dr. Forehand dated 3/14/2005 as CX 1. Although that report was not submitted, a report by Dr. Forehand dated November 25, 2005 is of record, and I deem that to be CX 1. Claimant refers to DX 2 as a report of Dr. Baker dated 6/22/06 that "was submitted in clarification of Dr. Baker's Deposition taken on 9/26/06." Because Dr. Baker's deposition testimony of 9/26/02 is found at DX 22, I deem the 06 date to be a clerical error. However, the report of 6/22/06 is not of record. Ergo, there is no evidence identified as "CX 2". I find no prejudice to Claimant in this omission, as I note that Dr. Baker addressed and amended that report in his report of October 30, 2006, identified as CX 7. Specifically, the doctor referred to evidence he summarized in that report that is not under consideration, such as Dr. Broudy and Dr. Fino's opinions and test findings.

with his children and grandchildren because he loses his breath. Tr. at 23. Claimant experienced problems breathing while he was still working in the mines. Tr. at 30. His breathing problems have not improved over time. Tr. at 31.

Claimant last worked in 1997, when the mine shut down. He was 41 years old at the time, and he has not worked since. Tr. at 24. Claimant was unable to find work, and said that he continues to experience back problems. Tr. at 25-26. He also has been treated by Dr. Mettu for sleep apnea. Id. He is also treated for hypertension and arthritis. Tr. at 26. He has not been hospitalized for his breathing problem. Id. Claimant smoked for 24 or 25 years, but has quit smoking. He estimated smoking a pack of cigarettes over a weekend, and one half of one pack each work day. Tr. at 27-28. He last smoked in 2002 or 2003. Tr. at 28.

Claimant also testified by deposition on July 18, 2002. DX 17. He stated that he is married to Emma, who does not work. DX 17 at 4. Claimant had breathing problems and back problems when he worked in the mines, and sought treatment at the Mud Creek Clinic. DX 17 at 9. He sees Dr. Maynard every month or two, and also sees a doctor at Mountain Comp. Id. at 11. Claimant described his medications, and described his medical treatment in a manner consistent with his testimony at the hearing before me.

C. Entitlement

Benefits are provided under the Black Lung Act for miners who are totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(a). "Pneumoconiosis" is defined as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. § 718.201(a). Because this claim was filed after January 19, 2001, Claimant's entitlement to benefits will be evaluated under the revised regulations set forth at 20 C.F.R. Part 718. In order to establish entitlement to benefits under Part 718, a claimant normally bears the burden of establishing the following elements by a preponderance of the evidence: (1) the miner has pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) the miner it totally disabled, and (4) the miner's pneumoconiosis contributes to his total disability. 20 C.F.R. § 725.202(d)(2)(i)-(iv); See Director, OWCP v. Greenwich Colliers, 512 U.S. 267 (1994); Perry v. Director, OWCP, 9 B.L.R. 1-1, 1-2 (BRB 1986).

1) Whether the Miner Has Pneumoconiosis

A finding of the existence of pneumoconiosis is determined pursuant to 20 C.F.R. § 718.202. In addition, the regulations permit an ALJ to give appropriate consideration to "the results of any medically acceptable test or procedure reported by a physician and not addressed in this subpart, which tends to demonstrate the presence or absence of pneumoconiosis." 20 C.F.R. § 718.107(a). Finally, the Benefits Review Board ("the Board") has held that all evidence relevant to the existence of pneumoconiosis must be considered and weighed. Mabe v. Bishop Coal Co., 9 B.L.R. 1-67 (1986) (the Board upheld a finding that the claimant had not established the existence of pneumoconiosis even where the X-ray evidence of record was positive).

20 C.F.R. § 718.202(a) Evidence

There are four means of establishing the existence of pneumoconiosis set forth at 20 C.F.R. §§ 718.202(a)(1) through (a)(4):

(1) X-ray evidence: § 718.202(a)(1).

(2) Biopsy or autopsy evidence: § 718.202(a)(2).

(3) Regulatory presumptions: § 718.202(a)(3):

(a) § 718.304 - Irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis.

(b) § 718.305 - Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment.

(c) § 718.306 - Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971.

and

(4) Physicians' opinions based upon objective medical evidence: § 718.202(a)(4).

The following is a discussion of the § 718.202(a) evidence of record:

1. Chest X-Ray Evidence - § 718.202(a)(1).

Under § 718.202(a)(1), the existence of pneumoconiosis can be established by chest X-rays conducted and classified in accordance with § 718.102.[4] An ALJ may utilize any reasonable method of weighing the X-ray evidence. Sexton v. Director, OWCP, 752 F.2d 213 (6th Cir. 1985). Generally, a physician's qualifications at the time he/she renders an interpretation should be considered. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32 (1985). It is well established that it is proper to credit the interpretation of a dually qualified (B-Reader and BCR) physician over the interpretation of a physician who is solely a B-Reader. Zeigler Coal Co. v. Director, OWCP [Hawker], 326 F.3d 894 (7th Cir. 2003) (complicated pneumoconiosis); Cranor v. Peabody Coal Co., 22 B.L.R. 1-1 (1999) (en banc on recon.); Sheckler v. Clinchfield Coal Co., 7

[4] A B-reader ("B") is a physician who has demonstrated a proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. § 37.51 A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii) (2001).

B.L.R. 1-128, 131 (1984). The Board has also held that greater weight may be accorded the X-ray interpretation of a dually qualified physician over that of a physician who is only a BCR. Herald v. Director, OWCP, BRB No. 94-2354 BLA (Mar. 23, 1995) (unpublished). In addition, an ALJ is not required to accord greater weight to the most recent X-ray evidence of record, but rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to be considered. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984); Gleza v. Ohio Mining Co., 2 B.L.R. 1-436 (1979).

The current record contains the following admissible chest X-ray evidence:[5]

Date of X-Ray	Date Read	Exhibit No.	Physician	Radiological Credentials	Interpretation
(1)					
2/26/02	2/26/02	DX 11	Baker	None noted	1/2
2/26/02	4/10/02	DX 11	Sargent	B-Reader; BCR	Quality only/abnorm.
2/26/02	12/18/06	CX 10	Baker	None	1/2
(2)					
3/14/05	10/26/06	CX 6	Forehand	B-reader	1/1
3/14/05	6/26/06	EX 4	Wheeler	B-Reader; BCR	Negative
(3)					
8/28/06	8/29/06	CX 3; 11	Forehand	B-reader	1/1
8/28/06	11/7/06	EX 8	Wheeler	B-reader; BCR	Negative
(4)					
6/20/02	6/20/02	EX 1	Wheeler	B-reader; BCR	Negative
(5)					
7/27/06	7/31/06	EX 5	Jarboe	B-reader	Negative
7/27/06	10/10/06	CX 5	Baker	None noted	1/2

The X-ray of February 26, 2002 was taken by Dr. Baker in conjunction with his OWCP sponsored evaluation of the Claimant. It was re-read by Dr. Baker, and is unrebutted. I find that this film is positive for the presence of pneumoconiosis.

Claimant submitted two X-rays by Dr. Forehand who interpreted them both as showing pneumoconiosis. Each of those readings was rebutted by a dually qualified physician who read them both as negative. I accord more weight to Dr. Wheeler's interpretations, and find that the X-rays of August 29, 2006 and March 14, 2005, are negative for the presence of

[5] Although Claimant's evidence summary report reflects some reliance upon the X-ray of 7/10/02, found at DX 12, Claimant also submitted Dr. Forehand's reading of a later film, dated March 14, 2005. I have considered the later film, submitted and identified as CX 6. In addition, Claimant submitted Dr. Baker's readings of films of September 11, 2002 and November 9, 2002 (CX 9 and 8), which I have excluded as being in excess of the regulatory limits for his case in chief, and being not admissible as rebuttal.

pneumoconiosis. Even if I were to accord equal weight to the readings of record, the result would not be probative because the evidence would be in equipoise.

The film of June 20, 2002 was interpreted as negative by a dually qualified physician, and was not rebutted. I find this film negative.

The film of July 27, 2006 was interpreted as negative by a B-reader, and positive by Dr. Baker, who has no specialized qualifications to interpret X-rays. I accord greater weight to the interpretation of the B-reader, and find that this film is negative for the presence of pneumoconiosis.

Considering the X-ray evidence on the whole, I find that the preponderance is negative for the presence of pneumoconiosis. Accordingly, I find that Claimant has failed to establish the presence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(1).

2. Biopsy or autopsy evidence - § 718.202(a)(2).

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. 20 C.F.R. § 718.202(a)(2). This method is unavailable here because the current record contains no such evidence.

3. Regulatory presumptions - § 718.202(a)(3).

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy or equivalent evidence of complicated pneumoconiosis which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. § 718.305(e). Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these presumptions are applicable, the existence of pneumoconiosis has not been established pursuant to 20 C.F.R. § 718.202(a)(3).

4. Physicians' opinions - § 718.202(a)(4).

The fourth way to establish the existence of pneumoconiosis under § 718.202(a) is set forth as follows in subparagraph (4):

> A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine

employment" and "includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis." A "reasoned opinion" is one that contains underlying documentation adequate to support the physician's conclusions. Fields v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based his diagnosis. Fuller v. Gibralter Coal Co., 6 B.L.R. 1-1291 (1984). An unreasoned or undocumented opinion may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-155 (1989).

The record contains the following physicians' opinion evidence:

Glen Baker, M.D. (DX 11; DX 22; CX 4; CX 7)

On February 26, 2002, Dr. Baker conducted the OWCP sponsored pulmonary evaluation of the Claimant. Dr. Baker documented Claimant's stated 24 years of coal mine employment underground which ended in September, 1997. Claimant's history of a back injury, hiatal hernia, gout and elevated cholesterol were recorded. Dr. Baker reported Claimant's symptoms of frequent colds, wheezing, chronic bronchitis, allergies, arthritis and high blood pressure. Claimant's smoking history of ½ pack of cigarettes per day from age 18, continuing to the date of his examination was documented. Claimant reported having daily sputum, wheezing, dyspnea, cough, chest pain, orthopnea and ankle edema. Claimant's physical examination revealed no reported abnormalities. An X-ray was read by the doctor as positive for coal workers' pneumoconiosis, and a mild restrictive defect was observed on pulmonary function study (PFS), and moderate resting arterial hypoxemia was noted on arterial blood gas studies (PFS). An EKG showed normal rhythm, with ST-T changes. DX 11.

Dr. Baker testified by deposition on September 26, 2002, and described the results of his physical examination of the Claimant. The doctor explained that his reading of the X-ray showed "changes that may be consistent with coal workers' pneumoconiosis". DX 22 at 7. The doctor found the changes compatible with an ILO rating of 1/1, or simple pneumoconiosis. Id. Dr. Baker observed that Claimant's cooperation on PFS was fair, and that the test results showed a mild pulmonary impairment. Id. at 8. The ABS results also showed an impairment. DX 22 at 10. Dr. Baker concluded that "smoking could cause a decrease in the oxygenation and the obesity could cause a restrictive ventilatory defect", and further stated that both conditions could "cause blood gas diminution". Id. Dr. Baker concluded that the Claimant retains the respiratory ability to return to work, but thought he might have difficulty with bronchitis and hypoxemia. DX 22 at 11. Dr. Baker did not find Claimant totally and permanently disabled due to pneumoconiosis. Id.

In a letter dated September 14, 2006, Dr. Baker addressed a report that he prepared, dated June 26, 2006[6], in which he discussed his review of X-rays that were read by Dr. Wheeler. Despite the negative readings, Dr. Baker affirmed his belief that Claimant has coal workers' pneumoconiosis and a disabling value of hypercarbia and hypoxia on blood gas studies. CX 4.

Dr. Baker also submitted a more detailed report in which he discussed all of the evidence, including his examination of the Claimant and all of his written reports, as well as those prepared

[6] As discussed herein, that report is not of record.

by other physicians of record. CX 7. Dr. Baker addressed his report of June 26, 2006, and corrected what he maintained was an error in his opinion. Dr. Baker stated that he made

> an error in saying that the miner did retain the respiratory capacity to return to work. The arterial blood gasses were at the disability level, and he would not be able to do the work of a coal miner or comparable work in a dust-free environment. The rest of that report was basically reviewing the information that is currently available. Dr. Broudy, Dr. Fino and myself, all found arterial blood gases studies that would meet the disability criteria, and Dr. Dahhan's were borderline.

CX 7 at 3. Dr. Baker concluded that because Claimant "had X-rays read by three B-readers as positive and with the disabling degree of arterial blood gases, that he had a totally disabling pulmonary condition secondary to his coal dust exposure and the presence of coal workers' pneumoconiosis." Id. Dr. Baker noted Dr. Forehand's opinion of March 14, 2005, wherein that physician found pneumoconiosis and a "disabling degree of arterial oxygenation". CX 7 at 3.

In a report of October 30, 2006, accompanied by answers to a questionnaire dated November 1, 2006, Dr. Baker discussed Dr. Dahhan's reports of September 16 and 23, 2002, in which the physician found spirometry results invalid, and concluded that Claimant had an obstructive airway disease due to smoking. CX 7 at 3. Dr. Baker observed that Dr. Dahhan did not address the disabling values on ABS, but concluded that Claimant did not retain the capacity to return to coal mine or comparable work due to his smoking-related pulmonary condition. Id.

Dr. Baker estimated Claimant's smoking history to be between 15 and 20 pack years, and noted his 24 years of coal mine employment. The doctor found adequate objective evidence to associate Claimant's disability with his coal mine history. CX 7 at 4. Dr. Baker acknowledged that Claimant's smoking history may have contributed to his abnormal blood gases, but found a co-existing significant contribution from coal dust exposure. CX 7.

J. Randolph Forehand, M.D. (CX 1; CX 3; EX 6)

Dr. Forehand authored a report dated November 25, 2005, in which he summarized his examination of the Claimant on March 14, 2005. CX 1. The doctor observed Claimant's 22 year history of working underground in coal mines and his 10 and1/2 pack year history of smoking cigarettes. Dr. Forehand observed abnormal breath sounds and the presence of crackles upon examination, and an X-ray was read positive for pneumoconiosis, with ILO classification of s/q, 1/1. No airflow obstruction was shown on spirogram, and lung volumes were normal without restriction. DLCO was normal, but an arterial blood gas study produced abnormal results both resting and upon exercise. CX 1. Dr. Forehand concluded that Claimant was totally and permanently disabled from a "respiratory impairment, which arose at least in part from his coal mine employment and which would prevent his from returning to his last coal mining job." CX 1 at 2. The doctor found no "evidence that additional medical factors such as cigarette smoker's lung disease or congestive heart failure contributed to [Claimant's] complaints of shortness of

breath or respiratory impairment." Id. Dr. Forehand also discounted obesity as a factor in his respiratory impairment.

In his report of August 28, 2006, Dr. Forehand summarized the results of his examination of the Claimant of that date. Claimant's coal mine employment was noted to be 24 years in duration, and his smoking history was documented as consisting of " ½ to 1 pack of cigarettes daily 1978 to 2003." The doctor concluded that a chest X-ray showed fibrosis with an ILO classification of 1/1 without evidence of emphysema. Arterial hypoxemia was noted on arterial blood gas test, and restricted lung volumes were evident. Dr. Forehand observed that the results were similar to his evaluation of the Claimant in March, 2005. The doctor again concluded that Claimant was totally and permanently disabled. CX 3. He opined: "[f]urthermore the lack of emphysema on chest X-ray, obstructive lung disease on spirometry and a normal DLCO ruled out asthma and cigarette smoker's lung disease and the normal appearance of the main pulmonary arterial trunk lessened the likelihood of pulmonary hypertension as the cause(s) of [Claimant's] shortness of breath." CX 3 at 2. Dr. Forehand disagreed with Dr. Jarboe's attribution of Claimant's shortness of breath to his cigarette smoking, asthma or pulmonary hypertension, because the chest X-ray that Dr. Forehand took "showed no evidence of emphysema or pulmonary hypertension, the spirogram showed no evidence of obstruction, and the DLCO was normal." Id.

Dr. Forehand testified by deposition on June 19, 2006, and stated that he is board certified in pediatrics, allergy and immunology. EX 6 at 3. The doctor summarized his evaluations of Claimant, including the results of X-rays. Dr. Forehand acknowledged that nodulation that is typical of pneumoconiosis generally starts in the upper lung zone, and there was no nodulation in Claimant's upper zones. Id. at 7. In addition, the doctor noted that cigarette smoking and obesity can cause linear opacities characterized as "s" or "t", and acknowledged that the opacity he saw on X-ray was "s", rather that "p" or "q", which are consistent with pneumoconiosis. Id. at 8. Dr. Forehand agreed that smoking can cause the "s" opacities that he saw. Id. Dr. Forehand also noted that Claimant was "significantly obese". Id.

Dr. Forehand believed that spirometry results were normal, and did not indicate impairment. EX 6 at 11. He also performed a test that measures the gas exchange of the lungs and diffusion capacity, which was normal. EX 6 at 14. The doctor also described the results of blood gas studies, and noted that there was not much change between resting and exercise results, which he found significant. EX 6 at 15. Dr. Forehand explained that typically, PO2 levels increase with exercise. Id. The doctor stated that obesity can cause hypoxemia on resting blood gases, but not on exercise studies. Id. Dr. Forehand agreed that the hypoxemia shown on resting blood gas studies could have been caused or been significantly affected by Claimant's obesity. EX 6 at 16. Dr. Forehand eliminated cigarette smoking as a factor in Claimant's test results because his PFS and DLCO were normal. EX 6 at 18. The doctor agreed that smoking could cause hypoxemia, but would expect abnormal PFS and DLCO in that case.

A. Dahhan, M.D. (DX 20; 21)

In a report dated September 16, 2002, Dr. Dahhan summarized the results of his examination of the Claimant on September 11, 2002. The doctor documented Claimant's 24

years of coal mine employment and his smoking history of ½ pack per day commencing at age 20. Claimant's subjective symptoms of daily cough with clear sputum, intermittent wheeze and dyspnea on exertion was noted, and his medications were recorded. DX 20. The doctor's examination of Claimant's chest showed no abnormalities and EKG was normal. An X-ray was interpreted as "showing clear lungs with no pleural or parenchymal abnormalities consistent with pneumoconiosis being present. ILO classification is 0/0". Dr. Dahhan found the objective findings insufficient to diagnose pneumoconiosis. The doctor further concluded that Claimant's poor performance on spirometry testing prevented measurement of his ventilatory capacity. Dr. Dahhan found no evidence of pulmonary impairment or disability related to coal workers' pneumoconiosis. DX 20.

In a letter dated September 23, 2002, Dr. Dahhan reported his review of medical records from Dr. Broudy, which are not in consideration in this adjudication. DX 21. The doctor also reviewed Dr. Baker's report of his examination of the Claimant on February 26, 2002. Dr. Dahhan did not find sufficient evidence to change his opinion regarding the existence of pneumoconiosis. However, the doctor concluded that Claimant "does not retain the physiological capacity to continue his previous coal mining work or job of comparable physical demand based on various clinical and physiological parameters of his respiratory system." DX 20. Dr. Dahhan diagnosed Claimant with chronic obstructive lung disease, resulting from smoking. DX 21.

Thomas M. Jarboe, M.D. (EX 5; EX 7)

Dr. Jarboe examined Claimant on July 27, 2006, and summarized the results of his evaluation in a report dated July 31, 2006. EX 5. The doctor noted a 24 year history of working in underground mines, ending in October, 1997. Claimant described being short of breath and unable to walk 50 yards without dyspnea. He has a daily dry cough, and experiences some wheezing and chest pain on occasion, with swelling of his ankles as well. Claimant has used a CPAP machine at night for his sleep apnea for seven years. Claimant started smoking in his 20's and has smoked ½ to 1 pack of cigarettes a day, depending on his work scheduled. He smoked more on weekends, and quit in 2002 or 2003. Claimant's examination was negative for abnormalities, and no rales or wheezes were identified.

PFS, before and after dilators, suggested severe restrictive ventilatory defect, with no airflow obstruction. Response to bronchodilators was not significant. Lung volumes confirmed moderate restrictive defect, as indicated by some reduction of the vital capacity. EX 5. Diffusion capacity was mildly reduced, but normal when adjusted for lung volume. Arterial blood gas studies at rest were normal, and Claimant could not exercise long. His PO2 level fell from 94.2 to 72.5 after approximately three or four minutes. Oxygen saturation remained normal. The X-ray of July 27, 2006 showed no evidence of pleural changes consistent with pneumoconiosis. Dr. Jarboe classified the film as ILO 0/0. Dr. Jarboe diagnosed significant obesity, obstructive sleep apnea, hypertension and "probable bronchial asthma". EX 5 at 4. The doctor attributed the reduction in forced vital capacity to Claimant's obesity, and determined that bronchial asthma and possibly pulmonary emphysema was responsible for his air trapping. The doctor based his diagnosis of asthma on the types of medication that Claimant has used for years, and his reports of wheezing. The doctor characterized Claimant's smoking history as significant.

Dr. Jarboe also hypothesized that Claimant has "an element of pulmonary artery hypertension [which] can cause reduction in oxygen tension with exercise". EX 5 at 5. The doctor concluded that he has a totally and permanently disabling respiratory condition, with FVC levels below the standards for disability. He is unable to perform his coal mine employment. Id. Dr. Jarboe is Board certified in Internal Medicine, is a member of the National Board of Medical Examiners, holds a Diplomate in pulmonary disease and is a B-reader. EX 5.

In a report dated October 17, 2006, Dr. Jarboe addressed Dr. Forehand's conclusions, and summarized his findings. EX 7. Dr. Jarboe disagreed with Dr. Forehand's conclusion that the spirogram showed findings consistent with a restrictive pattern "because the normal lung capacity excludes a diagnosis of restrictive disease." EX 7 at 1. Dr. Jarboe agreed that the spirogram showed no evidence of airflow obstruction, but maintained that the ratio of residual volume over TLC indicated the presence of airway disease. EX 7 at 2. Dr. Jarboe disagreed with Dr. Forehand's opinion that the test results ruled out asthma and cigarette smoker's lung disease. He agreed that if present, the emphysema would be of a mild degree. Dr. Jarboe believed that his diagnosis of bronchial asthma was supported by the difference between the results of the two PFS's that Dr. Forehand conducted. EX 7 at 2. Dr. Jarboe's opinions were not affected by Dr. Forehand's opinions. He continued to maintain that the record fails to establish the presence of a dust induced lung disease. EX 7 at 3.

20 C.F.R. § 718.107(a): "Other Medical Evidence"

20 C.F.R. § 718.107(a) allows an ALJ to give appropriate consideration to the results of any medically acceptable test or procedure reported by a physician and not addressed in this subpart, which tends to demonstrate the presence or absence of pneumoconiosis. The party submitting the test or procedure bears the burden to demonstrate that the test or procedure is medically acceptable and relevant to establishing or refuting a claimant's entitlement to benefits. 20 C.F.R. § 718.107(b).

Dr. Sargent read the X-ray of February 26, 2002 for quality, and noted the presence of an abnormality and further questioned whether Claimant had a smoking history. DX 11.

Discussion

Although I have found that the preponderance of X-ray evidence does not establish the existence of pneumoconiosis, the film that Dr. Baker read as negative has been unrebutted. In addition, he specifically relied upon X-rays by B-readers for his opinion. Dr. Baker found it reasonable to rely upon the positive X-ray readings of record in finding that Claimant had pneumoconiosis due to his coal mine exposure, but failed to reconcile the positive readings with the negative readings by dually qualified physicians. I note that Dr. Baker addressed the evidence regarding the possible cause for the hypoxemia noted on arterial blood gas tests, including Claimant's smoking history and obesity. Although Dr. Baker at first characterized Claimant's respiratory impairment as "mild" (DX 22), four years later he changed his opinion, based upon his review of all of the evidence of record, most significantly, the arterial blood gas studies that were at disability levels. Although Dr. Baker's opinions were supported by documentary evidence, they are not entirely supported by the evidence. Despite acknowledging

that Claimant's smoking and obesity could be responsible for his test results, the doctor concluded that he had pneumoconiosis on the basis of X-rays that have been contradicted. I find that Dr. Baker reached his opinion in a conclusory fashion, and I accord his opinion diminished weight.

Dr. Forehand rejected Claimant's smoking history as a potential cause for his respiratory impairment, noting no evidence of emphysema on X-rays. I find that Dr. Forehand's opinion is compromised by inconsistencies with the objective evidence. A dually qualified physician, Dr. Barrett, read one film for quality, and questioned Claimant's smoking history. DX 11. Dr. Forehand reached his conclusions on the results of his PFS, and ABS, discounting any possibility that the disabling values on ABS could be attributed to Claimant's smoking history or obesity. Dr. Forehand acknowledged that medically those conditions could produce the objective test results, but nevertheless ruled them out. The doctor acknowledged that his interpretation of an X-ray was not consistent with the findings typical of pneumoconiosis, but ruled out smoking, asthma or pulmonary hypertension based on the lack of obstruction on spirogram. His opinions about the cause of Claimant's abnormal arterial blood gas studies are not fully reasoned, as he fails to discuss X-rays that were interpreted as negative for pneumoconiosis. EX 6 at 8. I find that Dr. Forehand's opinions are not internally consistent, and I accord them limited weight.

Dr. Dahhan's opinion is consistent with the evidence that he reviewed; however, he relied entirely upon objective tests that are older than other test results of record, and did not examine any of the later developed evidence. His opinion that Claimant has chronic obstructive lung disease is not entirely in accord with the preponderance of the evidence. I accord limited weight to Dr. Dahhan's opinion, because he reviewed only the earliest developed evidence of record, and a significant amount of evidence was developed years later. It has been recognized that pneumoconiosis is a progressive and irreversible disease, and it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989)(en banc).

Dr. Jarboe's opinions are well supported by the record, and he provides well reasoned explanations for concluding that the objective record does not show the presence of pneumoconiosis. The doctor found that Claimant's symptoms, treatment, and test results were consistent with asthma for which he did not assign a specific cause. Although the relationship between Claimant's smoking history and emphysema could be inferred from the doctor's conclusion that Claimant's smoking history was significant, the doctor was equivocal about whether Claimant has emphysema, and stated that "emphysema, if present, would be mild." EX 7.

I find that Dr. Jarboe's diagnoses for asthma, and bronchial asthma, with the possibility of a diagnosis for emphysema, fall within the regulatory legal definition of pneumoconiosis, but further observe that he did not relate those conditions to coal dust exposure. See, Robinson v. Director OWCP 3 BLR 1-1798.7 (1981). The doctor relied entirely upon negative X-rays for ruling out pneumoconiosis, and did not sufficiently explain how his substantial coal mine employment would play no role in his condition. I note Dr. Jarboe's credentials, but find that his opinions are not entitled to substantial weight.

I find that the medical opinion evidence fails to establish that Claimant has pneumoconiosis. Considering all of the evidence, it fails to establish this element of entitlement.

2) Whether Pneumoconiosis Arose Out of Coal Mine Employment

In the present case, because it has been accepted that Claimant worked for at least twenty (20) years in coal mine employment, a rebuttable presumption would arise to connect pneumoconiosis to coal mine employment. 20 C.F.R. § 718.203(b). Because Claimant has not successfully established the threshold matter of whether the Miner had pneumoconiosis, by implication the issue of causation is resolved. The presumption, therefore, is not triggered and analysis under this prong is unnecessary.

3) Whether the Miner Was Totally Disabled

In addition to establishing the presence of coal workers' pneumoconiosis, in order for Claimant to prevail under the Act, he must establish that the Miner was totally disabled due to a respiratory or pulmonary condition prior to his death. 20 C.F.R. § 718.204(a). A miner is considered totally disabled within the Act if "the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner:

> (i) From performing his or her usual coal mine work; and
> (ii) From engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time."

20 C.F.R. § 718.204(b)(1). The regulations at 20 C.F.R. § 718.204(b) provide the following five methods to establish total disability: (a) pulmonary function studies; (b) arterial blood gas studies; (c) evidence of cor pulmonale with right-sided congestive heart failure; (d) reasoned medical opinions; and (e) lay testimony. 20 C.F.R. §§ 718.204(b)(2) and (d). However, in a living miner's claim, a finding of total disability due to pneumoconiosis shall not be made solely on the miner's statements or testimony. 20 C.F.R. § 718.204(d)(5); Tedesco v. Director, OWCP, 18 B.L.R. 1-103 (1994). Further, a presumption of total disability is not established by a showing of evidence qualifying under a subsection of § 718.204(b)(2), but rather such evidence shall establish total disability in the absence of contrary evidence of greater weight. Gee v. W.G. Moore & Sons, 9 B.L.R. 1-4 (1986). All medical evidence relevant to the question of total disability must be weighed, like and unlike together, with Claimant bearing the burden of establishing total disability by a preponderance of the evidence. Rafferty v. Jones & Laughlin Steel Corp., 9 B.L.R. 1-231 (1987).

a) Pulmonary Function Studies

In order to demonstrate total respiratory disability on the basis of pulmonary function study evidence, a claimant may provide studies, which, after accounting for sex, age, and height, produce a qualifying value for the FEV1 test, and produce either a qualifying value for the FVC test or the MVV test, or produce a value of FEV1 divided by the FVC less than or equal to 55

percent. "Qualifying values" for the FEV1, FVC and the MVV tests are measured results less than or equal to values listed in the appropriate tables of Appendix B to 20 C.F.R. Part 718, 20 C.F.R. § 718.204(b)(2)(i).

The following pulmonary function studies ("PFSs") are contained in the record:

Date	EX. No.	Physician	Age/ Ht.	FEV_1	FVC	MVV	Effort	Qualifies
9/11/02	DX 20	Dahhan	46 67"	2.09 1.97*	2.60 2.52*	75 61*	Poor	INVALID
2/26/02	DX 11	Baker	46 67 ¼"	2.11	2.60	n/a		**No**
8/28/06	CX 3	Forehand	50 67"	2.28 2.45*	2.90 2.86*	66.5 51.0*	Good	**No**
7/27/06	EX 5	Jarboe	50 68"	1.95 2.10*	2.44 2.41*	71 69*	Good	**Yes**

* Post-bronchodilator values

Dr. Dahhan invalidated the results of the test that he performed. The tests that Dr. Baker performed were validated by Dr. Younes. DX 11. Dr. Forehand's results did not squarely qualify under the quality standards, but were close to those of Dr. Jarboe's results, which were obtained one month before his. I find the evidence sufficient to demonstrate total disability.

b) Arterial Blood Gas Studies

To establish total disability based on Arterial Blood Gas Studies, the test must produce the totals presented in the Appendix C to 20 C.F.R. Part 718, 20 C.F.R. § 718.204(b)(2)(ii).

The record contains the following arterial blood gas study ("ABGs") evidence summarized below:

Date	EX. No.	Physician	pCO_2	pO_2	Qualifies[7]
2/26/02	DX 11	Baker	36	61	Yes
9/11/02	DX 20	Dahhan	33.8	66.0	Yes
7/27/06	EX 5	Jarboe	36.9 35	94.2 72.5*	Yes
8/28/06	CX 3	Forehand	33	65	Yes

* Values obtained during exercise

As the preceding table demonstrates, all of the ABGs of record produced qualifying values under the regulations. As such, I find that the preponderance of the ABG evidence supports a finding of total disability.

[7] In order to qualify for total disability under arterial blood gas studies, Claimant's pCO_2 value would have to be equal to or lower than the given pO_2 levels found in the "Qualifies" column of this chart.

c) Cor Pulmonale Diagnosis

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided heart failure. 20 C.F.R. § 718.204(b)(2)(iii).

There is no evidence of cor pulmonale with right-sided congestive heart failure in the record. Accordingly, I find that Claimant has not demonstrated total disability pursuant to § 718.204(b)(2)(iii).

d) Reasoned Medical Opinion

The fourth method for determining total disability is through the reasoned medical judgment of a physician that Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful employment. Such an opinion must be based on acceptable clinical and laboratory diagnostic techniques. 20 C.F.R. § 718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. Fields v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id. An unreasoned or undocumented opinion may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-155 (1989).

Each physician of record concluded that Claimant was totally disabled from a respiratory condition, and could not return to his coal mine employment or similar work.

After weighing all of the evidence, I find that the record as a whole establishes that Claimant is totally disabled under the Act.

4) Whether Total Disability Was Due to Pneumoconiosis

The amended regulations at Part 725 mandate that a miner is eligible for benefits if his "pneumoconiosis contributes to [his] total disability." 20 C.F.R. § 725.202(d)(2)(iv). A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis is a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. 20 C.F.R. § 718.204(c). Because Claimant has not successfully established the threshold element of presence of pneumoconiosis, analysis under this prong is unnecessary.

III. CONCLUSION

Based upon the foregoing, I find that Claimant has failed to establish that he is totally disabled due to pneumoconiosis. Accordingly, his claim for an award of benefits must be denied.

IV. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which Claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this claim, the Act prohibits the charging of any fee to Claimant for representation services rendered in pursuit of the claim.

ORDER

Claimant's claim for benefits under the Act is hereby DENIED.

A

Janice K. Bullard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).